through legislative changes. Formal RSA should be mainly a non-outcome based as from health outcome based pay for performance looks the most feasible, considering the local NHIF capacity. Legislation changes should be made in chapter 12 of the Drug act, article 45 of the Insurance act and to be created new section within chapter 4 of Ordinance 10 of NHIF. RSA implementation will improve the access to lifesaving treatment options for the patients with unmet medical needs while the scarce NHIF budget will be preserved within endorsed limits. **CONCLUSIONS:** RSA seems promising solution for balancing uncertainties for payers with market access for new and existing medicines, thus will allow NHIF efficiently to control and spend their limited budget while providing quality treatment to more patients in need.

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HEALTH CARE COVERAGE THROUGH PRIVATE HEALTH INSURANCE

Kornfeld M[1], Belgaied W[2], Toumi M[3]

[1]*Creativ-Ceutical, Paris, France,* [2]*Creativ-Ceutical, Tunis, Tunisia,* [3]*Aix-Marseille University, Marseille, France*

BACKGROUND: Achieving universal health coverage (UHC) is a common goal worldwide. As off today only some rich countries have succeeded to provide publically funded UHC to all their citizens. However, many low- and middle-income countries with a weak tax base are still far from achieving similar coverage despite a continuous increase in public and private healthcare expenditure. Patients in these countries have to rely on direct payments to finance their health care needs and in some regions these out-of-pocket (OOP) payments can account for up to 80 percent of total health expenditure. **DISCUSSION:** OOP represents a significant financial risk to households. Low-income families, in particular, are very vulnerable and run the risk of further impoverishment if they have to carry both health expenditures and indirect costs (loss of productivity) associated with their illness. Alongside public and out-of-pocket spending for covering patients private health insurance (PHI) represents an important third source of healthcare funding. PHI allows for risk-sharing and as such could play a critical role in securing low-income families access to treatment. So far, the contribution of PHI versus UHC remains limited but it is expected to grow significantly in the near future in emerging markets such as BRICS where it will be an important player for expanding the reach of novel treatments. The rapid economic growth, increased demand and gaps in healthcare coverage will pave the way for a greater uptake of PHI. In some African countries, despite PHI being urgently needed, extreme poverty may favor community based health insurance. **CONCLUSION:** Due to the low tax base in developing countries UHC has problem to develop thus exposing the low/medium income households to high financial risk. Extending PHI in those countries allows for risk sharing and thus could have important equity implications.

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COMPARISON OF PHARMACEUTICAL PRICING AND REIMBURSEMENT SYSTEMS IN TURKEY AND CERTAIN OTHER EU COUNTRIES

Atikeler K[1], Ozcelikay G[2]

[1]*Hacettepe University, Ankara, Turkey,* [2]*Ankara University, Ankara, Turkey*

This study examines; along with current situation in Turkey, pharmaceutical pricing methods, reimbursement methods and basic health indicators, within the scope of changing pharmaceutical policies, in Turkey, reference countries and the United Kingdom, the implementations of which are of utmost importance for other countries. Upon the research conducted, it was detected that the pharmaceutical pricing in Turkey has been performed on the basis of reference pricing system that takes Italy, Portugal, Spain, Greece and France as reference. The regulations regarding the reimbursement process are determined by SSI. The reimbursement system has been changed numerous times and the discount rates has incrementally risen. In pricing, on the other hand, drug companies face difficulties in economic terms because of the fact that price discount of high rates are implemented over the reference price and that the European currency of Euro is fixed at 2. Moreover, it has also been recognized that certain drugs have been hard to find within the market and the patients' access to medicines has become hindered. Although it is natural for Turkey to put restrictions on drugs budget to ensure sustainable drug financing, in order to maintain the existence of pharmaceutical industry and protect the patients' access to medicines; it would be more favorable in the development of the industry that the expectations of the stakeholders in the industry are taken into account in the policy making process. This would also help the already supported R&D activities to be sustainable as well. The positive and negative aspects of Turkey's offering the least expensive medicine should be examined. Whether being the country to supply the least expensive medicine is the correct objective or not in the international arena should seriously be discussed. It is recommended that how this situation affects Turkey's image in the outer world should be scrutinized.

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CLOSING THE FINANCIAL GAP OF ANTIRETROVIRAL AND HIV SUPPLIES FOR SUSTAINABILITY OF HIV NATIONAL RESPONSE IN THE DOMINICAN REPUBLIC

Valdez C[1], Barillas E[2], Diaz M[3], Mesa A[1]

[1]*Management Sciences for Health, Arlington, VA, Dominican Republic,* [2]*Management Sciences for Health, Arlington, VA, WA, USA,* [3]*Ministry of Health, santo domingo, Dominican Republic*

Since 2004 public provision of ARV in Dominican Republic (DR) has been funded, by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Until 2009 there was a gross correspondence between the increase in the number of treated cases and the funding. From 2009 to 2012, however, the number of cases grew at an average rate of 33.4% (2,958 cases) per year, whereas funding experienced an average decrease of 21.7% (965,382 USD) per year. In 2012, the Ministry of Health (MoH) carried out the first national quantification exercise for the 2013 procurement of medicines, under a standard forecasting methodology. The cost of ARV was estimated in USD 6.1 million; of which the GFATM would cover USD 3.6 million (59%). This was the first time that a financial gap of about USD 2.5 million (41%) was identified and recognized by all stakeholders. A political incidence and advocacy strategies based on evidence were established for national authorities, NGO's and international agencies to mobilize resources to close the gap. The GFATM's principal receptor identified a new international provider of ARVs, accounting for savings of USD 910 thousand. Finally, the MoH budgeted, for the first time, USD 1.9 million for the procurement of ARVs in 2013; turning the financial gap into a surplus USD 700 thousand. For 2015 GFATM funding was 0%; however the DR Government covered a 100% of ARV needs and they have been executing USD 6.8 millions/per year. The decrease of the international financial assistance for ARV, particularly by the GFATM, can be covered by the commitment of national resources to bridge the financial gap and a more efficient use of the resources already available. The estimation of needs, consensus building methodologies, political incidence and advocacy strategies used in DR are guarantees of the financial sustainability for the following years.

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PROPOSAL FOR A REGULATORY FRAMEWORK FOR HEALTH APPS TO ENSURE A PATIENT CENTERED COMPETITION BETWEEN PROVIDERS

Bierbaum M[1], Islamaj H[2], Schnick A[3], Bierbaum ME[4]

[1]*HS Aalen, Nürnberg, Germany,* [2]*Hochschule Ulm, Ulm, Germany,* [3]*Gedikom, Bayreuth, Germany,* [4]*BERSERCON, Nürnberg, Germany*

The number of newly developed and distributed health apps is legion and they are offered by healthcare providers, insurers and private companies alike. Although a sound business model is not always perceptible at first hand, it can be observed that in many cases payers and providers are either trying to bind patients with lock in effects and proprietary protocols or want to gather sensitive personal data for further use. New health care programs and solutions are rather made for marketing purposes than to serve the individual need of the customer (e.g. patient). Our project discusses the urgent need for regulatory rules ensuring that competition between providers of these health care apps serves the patients needs and leads to an improvement of patient relevant outcomes. In the course of the young lions "Health Parliament" the issue at hand was brought up by the authors in the board of competition at the example of the chronic disease of diabetes. To highlight the importance of continuous support in behavioral change we asked patients about their individual incentives and their expectations in a regulatory framework of health care competition to satisfy their needs. Following several discussions and a delphi-panel like process a regulatory framework was developed which could ensure that competitive forces act in a way that the patient's needs are met for all kind of chronic diseases. To align the competitive forces onto patient centered outcomes the following aspects need to be addressed: 1) Market access; 2) Quality assurance; 3) Protection of data privacy; 4) Open standards for interchangeability; 5) Pricing and reimbursement mechanisms. With our poster we would like to present our claims to an international audience to gain further insights on the topic and to foster the discussion into a more patient centered competition.

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PATIENT BEHAVIOUR AS A COST DRIVER IN THE MANAGEMENT OF CHRONIC DISEASE PATIENTS

Kornfeld M[1], Belgaied W[2], Toumi M[3]

[1]*Creativ-Ceutical, Paris, France,* [2]*Creativ-Ceutical, Tunis, Tunisia,* [3]*Aix-Marseille University, Marseille, France*

BACKGROUND: Maintaining chronic disease patients clinically stable after discharge is an important imperative for avoiding costly hospital readmissions. A good understanding of the patient's clinical risk profile is today considered the most important factor predictive of unfavorable patient outcomes. However, an often overlooked risk factor is patient behavior and patient decision drivers. Insights from the behavioral sciences can shed light on how individuals actually make decisions. Behavioral sciences have been used in marketing for years but are rarely used in the medical field. Recent studies from the UK have shown that up to 40% of the costs incurred for readmission/ emergency room visits are incurred by patients that should have been taken care of in the ambulatory care or at home. The behavioral drivers for these patients vary: not a good image of GPs, patients that are overly worried and anxious, an opportunity to get access to health care without an appointment. **DISCUSSION:** Not applying insights from the behavioral sciences to the medical field carries an important and avoidable cost for the health system caring for chronic disease patients. Healthcare should invest resources allowing to segment chronic disease patients at discharge, according to their behavioral profile, and provide support and education for those patients that are likely to burden the emergency rooms and hospitals for non-eligible reasons. **CONCLUSION:** Profiling chronic disease patients at risk of costly hospital readmissions based on insights from the behavioral sciences represents an opportunity to address an important cost driver that is currently overlooked in relation to the traditional clinical risk assessment.

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SOFOSBUVIR: THE FAILURE OF PRICING POLICIES IN THE EUROPEAN UNION

Lee D[1], Hanna E[1], El Hammi E[2], Rémuzat C[1], Toumi M[3]

[1]*Creativ-Ceutical, Paris, France,* [2]*Evidenz, Tunis, Tunisia,* [3]*Aix-Marseille University, Marseille, France*

BACKGROUND: Sofosbuvir, a breakthrough anti-HCV (hepatitis C virus) polymerase inhibitor, was first approved for early entry in 2012 in France. The product was granted a marketing authorisation in the United-States (US) and in the European Union (EU), by the end of 2013 and beginning of 2014, respectively. Shortly after licensing, most HTA bodies assessed sofosbuvir; they acknowledged a major additional benefit and find it cost-effective for a price around USD 80,000 in US and USD 55,000 in EU for a 12-week course treatment. **DISCUSSION:** Sofosbuvir price may have led to health insurances (HI) bankruptcy in EU and to substantially increase HI premium in US. In EU, politicians reacted through an orchestrated media campaign; manufacturer was called to clarify the gap between production cost and price, as if price cost was the drug industry model, while value-based pricing was in force. The most active campaign happened in France where members of parliament and Health Minister multiplied press releases and presence